DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445131	A. BUILDING _____ B. WING _____	C 06/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NORTH	5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During investigation of Entity Reports #25751, #25964, #25503, #25338, #25273, #24893, #24870, #25476, and Complaints #24857, #25546 at Hillcrest North on June 9-11, 2010, no deficiencies were cited under 42 CFR Part 482.13 Requirements for Long Term Care.	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#5) and a complete medical record for one resident (#6) of fifteen sampled residents. The findings included: Resident #5 was admitted to the facility on April 16, 2010, with diagnoses including Congestive Heart Failure and Chronic Obstructive Asthma. Medical record review of a nurse's note dated	F 514	F-514 1. Resident # 5 was discharged from the facility to the hospital on 04/24/2010 and to date has not been readmitted to the facility. Licensed nurse that initialed treatment as being administered post discharge was counseled by the Director of Nursing on 06/10/2010. Resident #6 was discharged from the facility to Knox Area Rescue Ministries on 12/16/09 and to date has not been readmitted to the facility. Licensed nurse responsible for completing the discharge documentation was counseled on 06/09/10. 2. Discharged resident's medical records have the potential to be affected. Chart audit of facility discharges in the past 30 days was completed on 06/17/2010 by members of the Interdisciplinary team including Director of Nursing, Assistant Director of Nursing, Team Leader, Staff Development Coordinator and Medical Records Director to identify inaccurate or incomplete discharged medical records. 3. On 06/09/2010 - 06/16/2010, licensed nursing staff and Medical Records Director were in-serviced by the Staff Development Coordinator on documentation at time of discharge, complete medical records and documenting treatments only when resident is in facility.	6-17-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Quentle Williamson | Admin | 6-21-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 24 2010

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F 514	Continued From page 1 June 24, 2010, at 8:10 p.m., revealed the resident was transported to a hospital. Medical record review of a nurse's note dated June 24, 2010, at 11:40 p.m., revealed, "Pt is being admitted..." Medical record review revealed the resident did not return to the facility. Medical record review of a treatment record dated June 26, 2010, revealed a first shift nurse initialed a skin treatment as administered. Resident #6 was admitted to the facility on November 23, 2009, with diagnoses including Diabetes Mellitus and Obstructive Sleep Apnea. Medical record review of a physician's order dated December 16, 2009, revealed, "dc (discharge) today to KARM (Knox Area Rescue Ministries)." Medical record review of a nurse's note dated December 16, 2009, at 10:15 a.m., revealed, "A and O x 3 (alert and oriented times three) resp (respirations) even unlabored." Medical record review revealed no documentation regarding when the resident was discharged or the condition of the resident at the time of discharge. Interview with the director of nursing on June 11, 2010, at 11:15 a.m., in the lower level room adjacent to the elevator, confirmed Resident #5's medical record was inaccurate, and Resident #6's medical record was incomplete. C/O: #25715	F 514	4. 10% of discharged charts will be audited for a complete medical record at time of discharge weekly x 4 and monthly x 2 by the Director of Nursing, Assistant Director of Nursing or Team Leader. Results of findings will be reported to the Director of Nursing. The Director of Nursing will report findings to the Quality Assurance Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.	6-17-10

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